بسم الله الرحمن الرحيم

عنوان المحاضرة: Pelvic Inflammatory Disease

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Pelvic Inflammatory Disease (PID):

Infection of the upper genital tract (Endometritis, Salpingitis, Parametritis, Oophoritis, Tubo-ovarian abscess and/or Pelvic peritonitis)

Scope of the problem:

-PID is a common cause of maternal morbidity

-Delays of only a few days in receiving appropriate treatment → markedly ↑ the risk of sequelae which include infertility, ectopic pregnancy, chronic pelvic pain

-Sequelae may also have significant health care costs

Incidence:

-Exact prevalence is hard to ascertain

-Thought to be in the region of (1 – 3 %) of sexually active young women

Causes: -Most common → Ascending infection from endocervix

Causative Organisms: -Chlamydia Trachomatis -Neisseria Gonorrhea -Mycoplasma -Anaerobes

Risk Factors:

-Age < 25 yrs -Previous sexually transmitted infections

-New sexual partner -Multiple sexual partners

-Uterine instrumentation (e.g. Hysterosalpingography, D&C → they should take prophylactic Antibiotics)

-Postpartum endometritis

Protective Factors: -Usage of Intercourse barriers (e.g. condoms)

Diagnosis: (Exam Q)

Symptoms:

-Asymptomatic -Lower Abdominal Pain -Dyspareunia -Postcoital dysuria -Vaginal Discharge

Signs

-Cervical excitation (bilateral severe tenderness in bimanual examination

-Adnexal tenderness -Temperature > 38°C (in severe cases)

Investigations:

-Endocervical & HVS (High vaginal swab from the posterior fornix) -Elevated WCC & CRP

-Vaginal USS (probe tenderness & may show pelvic abscess, peritonitis) -Laparoscopy

D.D.	Differs by
Ectopic Pregnancy	Menstrual History, initially unilateral pain
Ovarian Accidents (e.g rupture cyst)	Initially unilat. pain (often mid-cyclic)
Appendicitis	GI symptoms, Rt. sided pain
Irritable bowel Syndrome	Central or Lt sided pain, No cervical excitation
IBD (Crohn's, Ulcerative Colitis)	Coliky central or Lt sided abd. pain, bowel symptoms
Urinary tract infection	Urinary symptoms ± Loin pain (chlamydial infections can be presented with urinary symptoms)

Complications: (Exam Q)

1-Tubo-Ovarian abscess 2-Fitz-Hugh-Curtis syndrome 3-Recurrent PID

4-Ectopic Pregnancy 5-Infertility 6-Chronic Pelvic Pain

Treatment: (Exam Q)

****Inpatient or Outpatient?**

-Indications for inpatient:

1-Surgical emergency can't be excluded 2-Clinically severe disease 3-Tubo-ovarian abscess

4-PID in pregnancy (Rare d.t. presence cervical plug, occurs in septic miscarriage)

5-Lack of response to oral therapy 6-Intolerance to oral therapy

****General Principles (V. Imp)**

1-Negative swab doesn't exclude PID, Early treatment is preferred

2-Multiple Antibiotic regimens are required

3-Patients should be reviewed after 72 hrs

4-Contact tracing & treatment of partner is essential (1st cause of recurrence is infected partner)

5-Intercourse should be avoided during course of treatment

6-Drainage may be required in case of Tubo-ovarian abscess

*******(Drugs names & doses aren't required)**

***Outpatient Management:**

Regimen A: Ofloxacin 400 mg twice daily ± metronidazole 500 mg orally twice daily for 14 days

Regimen B: Ceftriaxone 250 mg IM in a single dose or Cefoxitin 2 gm IM in a single dose + Probenecid 1 gm orally administered concurrently in a single dose, followed by Doxycycline 100 mg orally twice a day for 14 days

***Inpatient Management:**

Regimen A: Cefotetan 2 g IV every 12 hours Or Cefoxitin 2 g IV every 6 hours + Doxycycline 100 mg orally or IV every 12 hours

Regimen B: Clindamycin 900 mg IV every 8 hours + Gentamicin loading dose IV or IM (2 mg/kg of body weight), followed by a maintenance dose (1.5 mg/kg) every 8 hours.

Prevention:

1-Chlamydia screening program (done by Swabs or 1st catch urine specimens)

2-Prophylaxis during uterine instrumentation

3-Sexual Education 4-Barrier contraception